

## **HEALTH, NUTRITION AND POPULATION POLICY**

### **1. INTRODUCTION**

The Task Force on Health and Population Sector Policy, constituted by CPD, had prepared a Policy Brief on the sector in September 2001, just before the last general elections were held. The Brief was prepared on the basis of detailed meetings and discussions amongst the Task Force members and stakeholders representing different organisations and groups involved in this sector. The Policy Brief contained a number of recommendations for the government that would come to power after the elections of 2001.

The Task Force was reconvened and reconstituted in January this year to revisit its recommendations and assess the state of their implementation. With this in mind, the members of the Task Force held four meetings during March-April. In May, a regional consultation meeting was held in Rajshahi with various stakeholders, whose ideas and suggestions have been incorporated in this updated Policy Brief.

This document (a) summarises the main issues discussed and recommendations made in the Policy Brief of 2001, (b) highlights the performance of the health and population sector in recent years, as revealed by a recent independent review of the Health and Population Sector Programme (HPSP), and (c) outlines the main policies and measures of the present government, as contained in its election manifesto, the Interim Poverty Reduction Strategy Paper (I-PRSP) and the recent document entitled “Conceptual Framework for Health, Nutrition and Population Sector Programme (HNPSPP) prepared by the Ministry of Health and Family Welfare (MOHFW).

This document is organised in five sections. After the introductory remarks in Section 1, a summary of the Policy Brief of 2001 is provided in Section 2. The 3<sup>rd</sup> Section discusses the actions taken against the policy statements in the election manifesto of the ruling party. Section 4 briefly examines the performance of HPSP in recent years. Section 5 outlines the main policies and planned measures undertaken, or to be undertaken, by the present government in the health, nutrition and population sector.

### **2. SUMMARY OF POLICY BRIEF 2001**

The Policy Brief of 2001 (CPD 2001) analysed the situation pertaining to the health and population sector and came up with a series of observations and recommendations in the following broad areas: (1) commitment of the government, (2) family planning, (3) health promotion, (4) medical care, (5) paramedics, (6) nursing, (7) training, (8) sanitation, (9) nutrition, (10) immunisation, (11) standardisation of food and drugs, (12) mapping of diseases, and (13) gender disparities. A summary of the Policy Brief 2001 follows. Annex A presents detailed recommendations contained in the Brief and also notes the current implementation status.

## **2.1 Commitment of the Government**

The government should be committed to providing health care service, which is affordable and attainable, to its citizens. The government should focus on increasing health status, reducing health inequalities, ensuring access to social support network, improving the quality of basic amenities and choice of provider, and ensuring that every household pays a fair share according to its ability. For the poor and vulnerable, safety nets need to be constituted.

## **2.2 Family Planning**

Family Planning (FP) needs to be recognised as the primary national problem and a target to achieve a net reproductive rate (NRR) of 1 by 2015 should be adopted. The government should delve into the causes of stagnating total fertility rate (TFR) and should adopt programmes to accelerate the decline in this rate. FP should be popularised through an intensive motivational campaign under the Behaviour Change Communication (BCC) programme. In addition to temporary methods of FP, clinical and permanent methods should be popularised in order to increase contraceptive prevalence rate (CPR) and ensure further decline in TFR. The involvement of men in FP should be increased.

## **2.3 Health Promotion**

The government needs to create greater awareness of, and provide services for, newly emerging diseases like hypertension, asthma, HIV/AIDS, heart diseases, etc. It should also take steps to combat common diseases, such as acute respiratory infection, tuberculosis and diarrhoea, which particularly afflict the poor. Special measures need to be initiated for combating malaria, dengue and kala-azar, which have recently registered a significant increase in the country. The issue of arsenic in drinking water needs to be urgently addressed and appropriate steps taken. Health education needs to be introduced in school curricula and their contents need to be widened. Steps need to be taken to make Upazila Health Committees play an effective role in promoting good health. These committees should be empowered to take local level decisions in terms of planning, management, and allocation of financial resources.

## **2.4 Medicare**

### **2.4.1 Government Service Providers**

In order to increase the access of the people to quality health care services, 5,000 new posts of doctors should be created in the next five years. There should be proper manpower planning to absorb medical graduates into the national medical service. There should be a doctor in every Union Health and Family Welfare Centre (UHFWC) and in a limited number of Community Clinics (CC) at the union and village levels. Recruitment rules should be reformed.

#### *2.4.2 Reform and Decentralisation*

A health sector reform body should be set up under the chairmanship of the Minister for Health and Family Welfare for overseeing the process of reform of the sector. Both administrative and financial authority, as far as possible, should be decentralised.

#### *2.4.3 Provision of Health Care Services*

Unless essential, the government should set up only autonomous Medicare units, which will provide for greater flexibility regarding appointment of personnel, contracting out of services, charging user fees, and introduction of new technologies, etc. As far as possible, outdoor treatment should be encouraged. All medical colleges and hospitals should accept referred patients. It should be the responsibility of such units to arrange admission into other hospitals if necessary. A network of referral system should be developed so that patients are assured of receiving treatment from health facilities.

#### *2.4.4 Payment for Health Care Services*

To the extent possible, free treatment in government hospitals should be ensured for those who cannot pay. Necessary funds should be arranged through user fees, government allotment, social organisations, etc. Gradual coverage through affordable insurance schemes needs to be introduced. Fees for providing medical advice or diagnostic purpose should be reviewed and controlled where necessary.

#### *2.4.5 Accountability and Stakeholder Participation*

Accountability should be ensured. Service associations, management committees, and professional organisations like Bangladesh Medical and Dental Council (BMDC) and Bangladesh Medical Association (BMA) should play a more effective role. Stakeholders should be involved in formulating policies and included in managing committees of hospitals, in order to increase accountability and transparency.

#### *2.4.6 Drug Issues*

The Drug Policy should be reviewed with the objective of striking a balance between the desire to support the local pharmaceutical industry and that of providing the citizens access to the latest development in the pharmaceutical sector. Among other things, protection should be provided to patented drugs for the legal duration of patents. The drug administration department should be strengthened and expanded to cover all districts of the country.

#### *2.4.7 Primary Health Care*

This is the most important tier of national health system. Attempts should be made to improve the quality of primary health care (PHC) and make it accessible to the people, especially the poor and vulnerable. Among other things, the following should be ensured. At least 60 per cent of the total expenditure in the health and population sector should be incurred in this area. The provision of essential services package (ESP) under HPSP should be strengthened and popularised. There should be a doctor in every UHFWC. The Community Clinics should be strengthened and the services of a doctor should be provided during certain fixed days every month. Regular supply of drugs and medicines to the CCs

should be ensured. Domiciliary services should continue. PHC and family planning services should be provided from the same centre. There should be greater involvement of the community.

#### **2.4.8 Secondary and Tertiary Health Care**

Hospitals should be autonomous with financial empowerment. Management Committees at hospitals should be strengthened and empowered to take administrative and financial decisions. Existing institutions should be expanded and strengthened. Existing specialised units should be strengthened and new ones should be set up only if the need is critical. New branches of sub-specialisation should be created in medical colleges so that patients do not need to come to Dhaka. The set-up should be absorbed in the revenue structure. Except where it is absolutely necessary, only autonomous units should be created.

#### **2.5 Paramedics**

The position of the paramedics should be re-evaluated and they should be given a greater role to play in matters of PHC in view of the prevailing situation in the health service delivery system and the socio-economic conditions. BMDC should be empowered to enable the paramedics to treat and prescribe medicines in a limited manner. The Upazila and District Health Committees should review the activities of such paramedics.

#### **2.6 Nursing**

Given the dearth of nurses, at least 4,000 posts of nurses should be created over the next five years. The post should be integrated within the revenue set-up upon completion of the development project. Nursing should function in hospitals as part of a unit. There should be expanded and improved arrangements for providing higher training/degree courses to nurses and personnel policy should encourage them to opt for such training. The Nursing Council, which oversees approval of nursing institution courses and administrative matters, should be reorganised to include more professionals.

#### **2.7 Training**

In order to improve the quality of health care services, regular training has to be provided to health and family planning personnel. Among other things, the following steps need to be taken. A training institute should be set up. The training should be need-based and should take into account the need and availability of different specialisations. A proper manpower survey should be conducted. The curriculum, besides focusing on professional needs, should also stress on management, attitudinal aspects, treatment and containment of common diseases.

## **2.8 Sanitation**

The citizens should be educated on proper sanitation. In this regard, stress should be given on BCC activities for informing the people about proper sanitation. These concepts should be included in school curricula around the country. The local government and the Public Health Engineering department need to be linked up for supporting sanitation measures. A comprehensive and doable plan regarding waste disposal needs to be formulated. Given the enormity of the problem of waste disposal, particularly in hospitals, steps need to be taken in phases to have a central waste system and appropriate legislation will need to be introduced.

## **2.9 Nutrition**

Proper knowledge about nutrition needs to be disseminated amongst the citizens. The National Nutritional Programme needs to be expanded to cover the entire country and adjusted on the basis of the gathered experience. In every upazila, a Nutrition and Health Education Unit should be set up.

## **2.10 Immunisation**

The present efforts in the field of immunisation should be evaluated and the existing programme needs to be continued with the commitment of greater resources. Government resources should be increased in order to offset decreasing foreign support. While the National Immunisation Day (NID) activities have been successful, the normal coverage of immunisation has not been encouraging. Other immunisation programmes covering, for instance, Hepatitis B need to be undertaken.

## **2.11 Standardisation of Food and Drugs**

The standardisation of food and drugs needs special attention. Presently, the Ministry of Health and Family Welfare covers issues related to drugs, while the Pure Food Ordinance, which is administered by the Local Government/Municipal Authorities, covers issues related to food standards. It is suggested that the administration should oversee food standards. The work of this facility should be backed by a definitive study on food standards that should serve as a benchmark for evaluating and maintaining standards. Till such study is in hand, the existing food laws should be strengthened and may include penal provisions for providing sub-standard drugs and unhygienic food to the public. This problem has been neglected but major health hazards stem from the consumption of unhygienic food and low quality drugs.

## **2.12 Mapping of Diseases**

There is a serious lack of availability of adequate information concerning the incidence and prevalence of diseases at both the regional and national levels. The incidence and prevalence of such diseases vary widely across different regions of Bangladesh. This indicates that there

is an urgent need to construct maps of all major diseases, on the basis of their incidence and prevalence, for each district. Without adequate mapping of diseases for each district, an effective health system cannot be developed in the country.

### **2.13 Gender Disparities**

Gender disparities are quite evident from sex differentials in some health indicators like post-neonatal and child mortality rates. This differential might be attributed, to a large extent, to the prevailing social norm of son preference. Discrimination against women stems from prevailing social norms and discourages women from realising their due share in all aspects of public and family life. Hence, this is a complex problem and requires long-term planning for minimising the impact of such discrimination on health. Without strong political and social commitment, the process of transformation of the traditional approach to gender, which is deeply rooted in society, cannot be readily realised. In addition, community participation remains a pre-condition for bringing about a change in the discrimination against women. Awareness measures and educational programmes need to be strengthened and the health service delivery to girls and women improved.

## **3. POLICY RECOMMENDATIONS IN THE ELECTION MANIFESTO OF THE RULING PARTY**

The ruling party in its election manifesto for the last parliamentary elections gave the following nine policy recommendations under the title of “Health”.

- 1) Budgetary allocation in the sector would be enhanced adequately and incrementally to ensure “Health For All” especially to improve the health status of the rural and low-income population.
- 2) Health Policy would be revised to make it more modern, timely and more people welfare oriented. In order to do so the current policy of making health services a commodity would be revised and reoriented accordingly.
- 3) More emphasis would be given on disease prevention activities
- 4) Public Health activities would be given more emphasis.
- 5) Hospital beds would be increased at all levels from the upazila to the district.
- 6) Establishment of all UHFWCs would be completed. Two doctors would be posted at each UHFWC.
- 7) Development of specialised doctors for all sections of medical care. Posts would be created and facilities constructed for deploying specialist physicians for complicated diseases, including cardiac and kidney specialists up to the district level.
- 8) A National Medical University would be established for registration of all public/private medical colleges, comprehensive medical education, quality assurance of medical care, proper and timely conduction of examinations, and for regular inspection of medical colleges.

- 9) Appropriate measures should be taken for making health administration more active.

Of these recommendations so far the process for implementing activities 2, 3 and 4 has been initiated. Processing of activity 6 has been partially initiated (posting of doctors has not been initiated as yet). No action has yet been taken on activities 5, 7, 8 and 9, while activity 1 has been reversed (the current year's budgetary allocations are the lowest compared to the last five years' allocations at current prices).

#### **4. PERFORMANCE OF HPSP**

How has HPSP performed? The latest Annual Programme Review (APR) of HPSP, carried out in January 2003 by an independent technical team, provides important findings on the performance of the programme. Although the technical team "focussed on developments over the last 12 months in relation to agreements reached after that last APR, it was encouraged to take a broader view of the whole HPSP period (APR 2003)." The APR report mentions that HPSP was "a bold move to consolidate external support for the sector." Although it did not cover all the development partner activities in the sector, it transformed 126 donor-funded projects into one programme implemented by MOHFW, which is considered to be a major innovation for Bangladesh. The major findings of APR 2003 are discussed below. Detailed performance indicators are presented in Annexes B and C.

##### **4.1 Health Outcome**

Health gains in Bangladesh over the past decades have been impressive, although it is unclear whether they have been generated more by economic growth and by improvements in education or by increasing expenditure on health services. Nevertheless, the reduction in population growth rate can be fairly attributed to intensive family planning activities, the reduction in communicable diseases at least partly to immunisation, and the reduction in mortality and morbidity from diarrhoeal diseases to the widespread use of oral rehydration therapy.

There is now some evidence that health gains are beginning to plateau. The top ten causes of mortality remain much the same as they were a decade ago, while the incidence of injuries and non-communicable diseases is rising faster than that of communicable diseases. In addition, tuberculosis and HIV-AIDS pose new threats.

##### **4.2 Service Delivery**

At the 'input' or 'process' indicator level, contraceptive prevalence continued to rise at the same rate as before, until 2001. Immunisation (both EPI for children and TT for mothers) remained at pre-HPSP levels. Antenatal care appears to have increased considerably in 2001. Nationally, safe delivery has not changed noticeably, but there is evidence that considerable progress has been made on emergency obstetrics care (EOC) services in certain areas.

Vitamin A distribution (through NIDs) has remained at high levels. TB services, particularly DOTS, have remained constant, although the persistently low case-detection rate, in the context of increasing multi-drug resistance, is of concern.

At the 'output' or 'impact' indicator level, fertility has remained stubbornly constant, but since 1991, well before HPSP started. It is possible that fertility would have declined if certain activities took place, both in awareness raising and improving clinical services, but it is also possible that families are having the number of children close to their desired family size. The apparent steep declines of the early 1990s in infant and child mortality have slowed down. Maternal mortality has shown an encouraging steady decline, partly resulting from the fertility decline, but presumably also due to the expansion of safe motherhood facilities over the past decade.

Malnutrition levels remain high and steady, but HPSP did little outside of Bangladesh Integrated Nutrition Programme (BINP), which was of limited coverage, to address this. The unified BCC activities charged with promoting awareness did not start properly functioning under HPSP.

One negative aspect of service delivery, not limited to the HPSP period, is growing inequity among certain important services. When the rich are many times more likely to use these services than the poor, then the system is not working as intended. This socio-economic inequity is particularly prominent where higher-level medical staffs are involved.

In the context of major changes in service delivery under HPSP, many of the important indicators have not improved but most have not deteriorated. The fact that such a small proportion of people use ESP services should raise a warning flag that issues of poor quality of care, and uncaring staff attitudes, result in negative perceptions among potential clients.

### **4.3 Organization and Management Development**

Many of the new activities, particularly where integration or unification of previous functions was involved, have utilised committee structures to encourage participation and inclusion in the process. Many of the areas under HPSP that have not progressed as planned are those depending on decisions to be made by committees, which have not functioned effectively, or in some cases, not at all. The creation of committees is a classic bureaucratic tactic for avoiding action on difficult issues. This appears to be the case in some of the integration issues in HPSP. In some cases, there were structural reasons for non-progress. For instance, several activities requiring integration could not proceed because the integrated organogram was not prepared and also because development budget posts traditionally are not included together with revenue budget posts.

Procurement has been one of the most problematic, partly because the shift from multi-project based procurement to a system concentrated in a few sources created a burden, which fell most heavily on the Central Medical Stores and Depot (CMSD), resulting in a 10-fold increase in the volume of purchases. CMSD received little technical or other support for several years.

#### **4.4 Financing**

The budget structure (artificial demarcation of development versus non-development) of the Ministry of Finance does not make integrated budget planning easy. However, MOHFW has been able to maintain the proportion of total budget allocated and spent on ESP well above the original threshold level (60%).

The current public and private sources of health finance combined are insufficient to achieve full coverage with even a basic package of services. The National Health Accounts estimated in 1996/97 the total health spending to be US\$10.6 per capita with over two-thirds coming from out-of pocket spending. This low public finance for health is insufficient to fully finance the existing health infrastructure or services for poor people. The WHO Commission on Macro Economics and Health revealed that the least-developed countries spend on average approximately US\$13 per person per year. The commission suggested an optimum expenditure of approximately US\$24 per capita, of which public sector outlays are US\$13.

MOHFW through HPSP has not been able to generate a significant real term increase in public sector health expenditures. Per capita spending in real terms is only as high now as it was in 1998 before HPSP started and it returned to that level only last year. In the first few years of HPSP, expenditure actually dropped by about 10% in real terms. The proportion of total GOB budget going to MOHFW has also been in steady decline since the start of HPSP. It fell from 6.5% to 6.1% to 5.2%, thus registering a 20% decline during the first three years of HPSP. The Ministry of Finance has made it clear that this trend is not a matter of policy and it is prepared to allocate MOHFW more funding provided the latter's ability to budget and spend more funds can be demonstrated.

Issues of payments for services, social and health insurance, retention of fees by the charging facilities, etc. remain largely at the discussion stage with some small-scale pilot phases implemented.

#### **4.5 Financial Management**

MOHFW's historical performance relating to planned budgets and actual expenditures further highlights its capacity problems. The actual overall HPSP spending, including this financial year (which is likely to be very close to planned budget) is 74% of the originally planned allocations, applying the original exchange rates. If the actual exchange rates are applied,

expenditures are 63% of the original allocations. Interestingly, development budget spending was markedly worse than revenue budget – 65% and 86% respectively.

Recent financial performance in terms of actual expenditure compared with funds budgeted provides a more positive outlook. The combined development and revenue budget expenditures for last year (2001-02) were 92% of the revised budget. This was a marked improvement over the previous year when spending represented 75% of the budget. This ‘planned-actual’ performance improvement seems due to improvement in overall financial management in as much as the mid-year revision process was much better. The budget was reduced by about 8% whereas in the previous year it was not adjusted by any significant percentage.

MOHFW has failed to develop a human resources strategy to hire and maintain staff at levels required to manage and deliver services efficiently. To do this it needs to alter the incentives for trained people to join and remain in public service. However, the government budget will need to be biased towards the health workforce with the skills required to deliver preventative and simple curative services in order to keep the wage bill within the budget ceiling.

Against the backdrop of these scenarios, the APR 2003 concludes that health outcomes in Bangladesh are improving, however, it is difficult to attribute these improvements to HPSP. The APR comments: *“Experience during HPSP suggests that, under tight budget constraints, subsidising services likely to be consumed by the poor has proven to be an ineffective targeting strategy. Exemptions from fees are unlikely to direct these subsidies precisely while provider incentives are weak and distorted. A different targeting strategy must be developed if I-PRSP objectives and MDG goals are to be achieved.”* Changes of the kind proposed by HPSP take a long to implement. They are subject to unforeseen difficulties and being predictable “performance dips”. Therefore, it is remarkable that there has been no catastrophic discontinuity in service provision, or decline in health outcome indicators, according to the APR.

## **5. PLANNED POLICIES AND MEASURES**

### **5.1 Interim Poverty Reduction Strategy**

The Vision of I-PRSP:

*“With the constitutional obligation of developing and sustaining a society in which the basic needs of all people are met and every person can prosper in freedom and cherish the ideas and values of a free society, the vision of Bangladesh’s poverty reduction strategy is to substantially reduce poverty within the next generation”*

Vision for the Health, Nutrition and Population Sector:

*“The Ministry of Health and Family Welfare seeks to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. It is a vision that recognizes health as a fundamental human right and, therefore, the need to promote health and to alleviate ill health and suffering in the spirit of social justice. This vision derives from a value framework that is based on the core values of access equity, gender equality and ethical conduct.”*

## **5.2 Highlights of the Strategy Paper**

The following are the highlights of I-PRSP vis-à-vis the health, nutrition and population sector:

- Addressing the pro-poor concerns in health remains unfinished and the sector needs to be given the priority it deserves. Developing a pro-poor agenda within the rubric of a sector-wide approach to health represents the biggest institutional challenge.
- Control of communicable diseases and improved maternal and child health to reduce high child and maternal mortality remains the highest public priorities.
- A package of essential health interventions with enhanced programmes of family planning catered to the needs of the poor would have strong poverty reducing effects as the improvements in health would translate into higher quality of children, lower income erosion due to health shocks, higher productivity, and higher economic growth.
- Implementation and access of current essential services package under sector-wide approach (SWAP) would be ensured with special focus on the health needs of the poorest and the most vulnerable both in rural and urban areas.
- Non-communicable diseases, including cardiovascular disease, diabetes, mental illnesses, and cancers, would be effectively addressed by relatively low-cost interventions, especially using preventive actions relating to diet, smoking, and lifestyle.
- Subsidised provisions in the supply of birth-control technologies, especially for poor women, would be continued.
- Emerging public health problems such as arsenic and dengue would receive priority attention in the medium-term period.
- Adequate measures would be taken to check the prevalence of HIV/AIDS as well as enhance the capacity to address the problem.
- Enhancing the capability of the public health sector to address past slippage and manage new threats to the health of the population would be a crucial part of the new strategy.
- Major programme interventions in the form of decentralised service delivery, increased local participation, particularly of the poor and women, access to modern health services, increased inputs for dealing with diseases and adverse health conditions that make the poor most vulnerable, and adequate capacity would be

designed and implemented. The NGOs could emerge as an important actor in this regard by delivering high-quality health care services, especially at the primary and secondary levels.

### 5.3 Medium-Term Policy Matrix

STRATEGIC GOALS/POLICY OBJECTIVES	MEDIUM TERM AGENDA	
	July 2003-June2004	July 2004-June2006
Ensure effective and equitable access to health services to all	<ul style="list-style-type: none"> <li>▪ Actions will be taken pursuant to the outcomes of the review of HPSP to design and implement the next phase.</li> <li>▪ Vacant posts of doctors and nurses will be filled in and required number of additional posts will be created.</li> <li>▪ The operational and maintenance budget of this sector will be increased.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Next phase of restructured sector wide programme will be implemented for development of the health, nutrition and population sector</li> <li>▪ Expenditure tracking studies will be conducted</li> </ul>

### 5.4 Key Steps in Developing the Health Content of the Strategy

Three broad aspects of pro-poor planning have been highlighted i.e., participation, poverty diagnosis, and objectives and actions. These are outlined below.

#### ➤ Stakeholder Participation

- Agreeing on the purpose and form of participation
- Identifying key stakeholders and participants in health and poverty
- Establishing a process and structure for participation

#### ➤ Health Poverty Diagnosis

- Identification of key health-poverty variables and health-poverty indicators
- Assessment of the extent of and trends in socio-economic inequities in health
- Assessment of who the poor are and the differences amongst them
- Analysis of the health-poverty process and the factors that contribute to socio-economic inequalities in health
- Identification and analysis of the major health problems of the poor and the consequences of those problems for the poor

- Critical appraisal of the capacity of current data and information systems to support pro-poor health planning and the subsequent monitoring and evaluation of poverty reduction activities and outcomes
- **Identifying and Prioritising Objectives and Actions**
  - Increasing the resource available for health and health related activities;
  - Ensuring that resources achieve maximum impact (i.e. are used efficiently and effectively to produce quality care with the minimum of waste);
  - Benefits of health spending and health interventions are distributed so that inequalities in health are reduced.

## **5.5 Present Government's Position and Actions Taken on HPSP**

After taking charge in October 2001, the present government has undertaken the following steps in the implementation of HPSP:

1. The government has decided to activate and run efficiently UHFWCs and strengthen the public-private-NGO partnership in taking services to villages.
2. The construction of remaining 775 UHFWCs has been undertaken. Around 90% of works of 200 UHFWCs is in progress and tender has been floated for another 300.
3. In addition to running the CCs in the public sector, the government has involved NGOs, on a purely experimental measure (pilot basis), for supervision of 12 CCs through a Memorandum of Understanding with a number of NGOs that were selected in consultation with DFID and USAID.
4. More attention has been given to BCC.
5. Two acts of legislation have been enacted, one on autonomy for a specialised hospital (ICMH) and one for safe blood transfusion. Another legislation for autonomy of the Kidney Hospital is underway.

## **5.6 Health, Nutrition and Population Sector Programme**

The government has drafted a conceptual framework for HNPSP for the period July 2003-June 2006 (MOHFW 2003). This document reflects the direction of GOB in the HNP sector for the next three years. It is the policy base of the HNPSP upon which the Programme Implementation Plan (PIP) will be developed and implemented. The main highlights of the document are mentioned below.

### **5.6.1 Goal and Purpose of HNPSP**

The stated *goal* of HNPSP is “sustainable improvement of the health, nutrition and family welfare status of the population of Bangladesh, especially of vulnerable groups, i.e., the poor, women and children, and the elderly.”

The stated *purpose* of the programme is “to increase the availability and utilisation of user-centred, effective, efficient, equitable, affordable and accessible quality services for a defined Essential Services Package plus other selected services.”

### **5.6.2 Objectives of HNPSP**

According to the HNPSP document, the priority objectives of the programme are to achieve the targets set in the Millennium Development Goals. The main objectives are the following:

- Reducing maternal mortality ratio
- Reducing total fertility rate
- Reducing malnutrition
- Reducing infant and under-five mortality
- Reducing the burden of TB
- Ensuring essential services through close-to-client (CTC) facilities
- Improving access to and quality of care of secondary and tertiary hospitals
- Control of communicable diseases, including kala-azar, dengue, leprosy, STD and HIV/AIDS

### **5.6.3 Major Interventions Planned**

The HNPSP document contains details of the interventions that are planned to be carried out in the HNP sector during July 2003-June 2006. A list of the major interventions is given below. These will be further elaborated in the PIP document, which is at the stage of being finalised.

- Essential services delivery
- Up-gradation of physical facilities and staff deployment
- District level hospital and specialised referral institutions
- Public health intervention and related inter-sectoral coordination
- Addressing population momentum
- Health system support
- Addressing health of specific target groups/areas
- Urban health
- Promoting public-private NGO partnerships
- Human resource planning and management
- Pre-service education
- In-service training
- Pro-poor health services
- Facilitating access by women and the poor
- Autonomy to institutions
- Capacity development for decentralisation

- Updating existing acts and enacting new regulations
- Governance
- Updating existing policies
- Facilitating stakeholder participation
- Sector-wide management
- Procurement of goods and services

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## RECOMMENDATIONS OF POLICY BRIEF 2001

SL. NO.	AREAS	RECOMMENDATIONS	STATUS
1.	<b>Commitment of the Government</b>	<ul style="list-style-type: none"> <li>◆ Provide quality health care services, which are affordable and accessible to all.</li> <li>◆ Focus on fundamental goals of improving health, enhancing responsiveness to the expectation of the people and assure fairness in bearing the costs of accessing health care in line with poverty reduction.</li> <li>◆ Government needs to play a more effective regulatory role.</li> <li>◆ Continue to serve as a provider of services.</li> <li>◆ Forge partnership with NGOs and civil society.</li> <li>◆ Involve the private sector in health care provision.</li> <li>◆ Enhance sectoral budgetary allocation</li> </ul>	<ul style="list-style-type: none"> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
2.	<b>Family Planning</b>	<ul style="list-style-type: none"> <li>◆ Target to achieve a net reproductive rate of 1 by 2015 should be adopted and supportive policies implemented.</li> <li>◆ The government should delve into the causes of the stagnating TFR and should adopt programmes to accelerate the decline in this rate.</li> <li>◆ In addition to temporary methods of family planning, clinical and permanent methods should be popularised in order to increase CPR and ensure further decline in TFR.</li> <li>◆ In order to popularise family planning, a more intensive countrywide motivational campaign, under BCC programme, should be launched.</li> </ul>	<ul style="list-style-type: none"> <li>◆ All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
3.	<b>Health Promotion</b>	<ul style="list-style-type: none"> <li>• The government needs to build greater awareness of and provide services for combating newly emerging diseases such as hypertension, asthma, reproductive tract infection, HIV/AIDS, heart disease, etc.</li> <li>• The issue of arsenic in drinking water needs to be taken up urgently by the health committees, hospitals and health professionals</li> <li>• To the extent treatment can be extended, this needs to be ensured.</li> <li>• The local government machinery has to be actively involved in the search for solutions to the problem and steps need to be taken to educate and sensitise the people.</li> <li>• The BCC unit of MOHFW should be activated and health education introduced in the school curricula and their contents need to be widened.</li> <li>• Steps need to be taken to make upazila health committees play an effective role in promoting good health.</li> <li>• The morbidity pattern and regional manifestation of diseases need to be mapped in order to help focus on health care efforts and conserve resources.</li> </ul>	<ul style="list-style-type: none"> <li>• Incorporated in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• Not incorporated in the next phase 3-year rolling HNPSP.</li> <li>• Incorporated in the HNPSP.</li> <li>• Incorporated in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• Incorporated in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• Not incorporated in the next phase 3-year rolling HNPSP.</li> <li>• Not incorporated in the next phase 3-year rolling HNPSP.</li> </ul>

SL. NO.	AREAS	RECOMMENDATIONS	STATUS
<b>4.</b>	<b>Medicare</b>		
4.1	<i>Government Service Providers</i>	<ul style="list-style-type: none"> <li>• Five thousand new posts of doctors should be created as an initial target in the next five years.</li> <li>• There should be a doctor available in every UHFWC and in CC for a fixed number of days.</li> <li>• Personnel (doctors and essential complementary staff) appointed under the development projects or in the revenue non-cadre positions should be integrated into the cadre service.</li> <li>• A committee, headed by the Secretary, Establishment Division, should frame recruitment rules, which would need to be periodically revised in view of the creation of new specialised posts, under the overall guidance of MOHFW.</li> </ul>	<ul style="list-style-type: none"> <li>• Not incorporated in the next phase 3-year rolling HNPSP.</li> <li>• For UHFWC incorporated, for CC not incorporated.</li> <li>• Process incorporated.</li> <li>• Not incorporated.</li> </ul>
4.2	<i>Reform and Decentralisation</i>	<ul style="list-style-type: none"> <li>• A health sector reform body should be set up under the chairmanship of the Minister of Health and Family Welfare for overseeing the process of reform of the sector. Both administrative and financial authority, as far as possible, should be decentralised.</li> <li>• Integration of Health and Family Planning services</li> </ul>	<ul style="list-style-type: none"> <li>• Not incorporated in the next phase 3-year rolling HNPSP.</li> </ul>
4.3	<i>Provision of Health Care Services</i>	<ul style="list-style-type: none"> <li>• Unless essential, the government should set up only autonomous Medicare units, which will provide for greater flexibility regarding appointment of personnel, contracting out of services, charging of user fees, and introduction of new technology, etc.</li> <li>• All medical colleges and hospitals should accept referred patients. It should be the responsibility of such units to arrange admission in other hospitals if necessary.</li> <li>• A network of referral system should be developed so that patients are assured of receiving treatment from health facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Incorporated in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• Not incorporated in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• Incorporated in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
4.4	<i>Payment for Health Care Services</i>	<ul style="list-style-type: none"> <li>• To the extent possible, free treatment in government hospitals should be ensured for those who cannot pay.</li> <li>• Necessary funds should be arranged through user fees, government allotment, social organisations, etc.</li> <li>• Gradual coverage through affordable insurance schemes needs to be introduced.</li> <li>• Fees for providing medical advice or diagnostic purpose should be reviewed and controlled where necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>

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SL. NO.	AREAS	RECOMMENDATIONS	STATUS
4.5	<i>Accountability and Stakeholder Participation</i>	<ul style="list-style-type: none"> <li>• Accountability of the health care providers should be ensured.</li> <li>• Service associations, management committees, and professional organisations should play a more effective role in ensuring such accountability.</li> <li>• Stakeholders should be involved in formulating policies and included in the managing committees of hospitals in order to enhance accountability and transparency in the public health care system.</li> <li>• The local hospital management committees as well as the district and upazila health committees should initiate their own development plans.</li> <li>• To ensure accountability, doctors need to be recruited by the local body so that the services provided by the doctors can be monitored and remedial measures regarding the problems at the local health complex or clinic can be promptly taken.</li> <li>• Main consumers in stakeholder groups from village level should be consulted for planning process.</li> <li>• The role of civil societies should be clearly delineated.</li> </ul>	<ul style="list-style-type: none"> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP from 1<sup>st</sup> July 2003.</li> </ul>
4.6	<i>Drug Policy</i>	<ul style="list-style-type: none"> <li>• The Drug Policy should be reviewed.</li> <li>• The objective would be to bring about a balance between the desire to support the local pharmaceutical industry and that of providing the citizens with the opportunity to avail themselves of the latest developments in the pharmaceutical sector.</li> <li>• Whilst protection should be provided to patented drugs for the legal duration of the patent, it should be reconciled with the need to provide people with drugs and medicines at the least cost.</li> </ul>	<ul style="list-style-type: none"> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
4.7	<i>Primary Health Care</i>	<ul style="list-style-type: none"> <li>• Attempts should be made to improve the quality of PHC and make it accessible to the people, especially the poor and the vulnerable.</li> <li>• Sixty per cent of the total expenditure in the health sector should be incurred in PHC.</li> <li>• The provision of ESP under HPSP should be strengthened.</li> <li>• There should be a doctor in every UHFWC.</li> <li>• The CCs should be strengthened and the services of a doctor should be provided during certain fixed days every month. The CC would be the focal point for providing ESP at the village level. A regular supply of drugs and medicines to the CCs should be ensured.</li> </ul>	<ul style="list-style-type: none"> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>

SL. NO.	AREAS	RECOMMENDATIONS	STATUS
		<ul style="list-style-type: none"> <li>• Domiciliary services should continue.</li> <li>• There should be greater involvement of the community, i.e., local government, civil society, community groups in the PHC process.</li> <li>• NGOs should be encouraged to provide PHC services and should also meaningfully be involved in the functioning of the CCs.</li> <li>• Greater effort should be invested in reducing maternal and child mortality. Post and antenatal care should, in particular, be stressed and doctors and paramedics dealing specifically with PHC should be proficiently trained on the subject.</li> </ul>	<ul style="list-style-type: none"> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
		<ul style="list-style-type: none"> <li>• Training of Traditional Birth Attendants should be initiated and should continue parallel to the policy to replace them with trained paramedics and doctors.</li> <li>• Emergency Obstetrics Care should be provided in every Upazila Health Complex.</li> <li>• Universal coverage of Vitamin A, and iron and calcium consumption should be ensured.</li> </ul>	<ul style="list-style-type: none"> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• Was planned under HPSP. Again planned for implementation in the next phase 3-year rolling HNPSP.</li> </ul>
4.8	<i>Secondary and Tertiary Health Care</i>	<ul style="list-style-type: none"> <li>• Hospitals should be semi-autonomous with full financial empowerment to generate and use their own revenues.</li> <li>• Management Committees at the hospitals should be strengthened and empowered to take administrative and financial decisions.</li> <li>• The DG Health should be able to transfer the Civil Surgeon and other health care officials below him/her in rank.</li> <li>• The existing institutions should be expanded and strengthened.</li> <li>• The existing specialised units should be strengthened and new ones should be set up only if the need is critical.</li> <li>• The number of health specialists needs to be increased.</li> <li>• Hospitals should be empowered to contract and hire specialists from abroad to provide hands-on training on new technology.</li> <li>• Hospitals should have multi-disciplinary facilities for catering to the needs of the patients.</li> </ul>	<ul style="list-style-type: none"> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>

SL. NO.	AREAS	RECOMMENDATIONS	STATUS
5.	<b>Paramedics</b>	<ul style="list-style-type: none"> <li>• The position of the paramedics should be re-evaluated and they should be given a greater role in matters of PHC in view of the prevailing situation in the health service delivery system and the prevailing socio-economic conditions of the masses.</li> <li>• A committee should be set up to suggest policy measures for ensuring more effective training and use of such paramedics.</li> </ul>	<ul style="list-style-type: none"> <li>• Was planned under HPSP. Again planned for implementation in the next phase 3-year rolling HNPSP.</li> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
6.	<b>Nursing</b>	<ul style="list-style-type: none"> <li>• Urgent measures need to be undertaken to create new posts for substantially enhancing the number of nurses over the next five years so as to bring Bangladesh's nurse-population ratio to a level commensurate with those already attained in our neighbouring countries.</li> <li>• Nurses should function in hospitals as part of a unit. Arrangements for providing higher training/degree courses to nurses should be expanded and substantially improved. A personnel policy for nurses with appropriate incentives should encourage them to opt for such training.</li> <li>• Training programmes for substantially expanding the primary intake of nurses should be initiated in the public sector. Adequate incentives should also be provided to the private sector to invest in such training facilities which should be regulated for quality.</li> </ul>	<ul style="list-style-type: none"> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
7.	<b>Training</b>	<ul style="list-style-type: none"> <li>• Regular training has to be provided to health and family planning personnel.</li> <li>• A training institute should be set up.</li> <li>• Training should be need based and should take into account the need and availability of different specialisations.</li> <li>• A proper manpower survey should be conducted.</li> <li>• The curriculum, besides focusing on professional needs, should also be stressed on management, attitudinal aspects, treatment and containment of common diseases.</li> </ul>	<ul style="list-style-type: none"> <li>• Planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>

SL. NO.	AREAS	RECOMMENDATIONS	STATUS
8.	<b>Sanitation</b>	<ul style="list-style-type: none"> <li>• Bangladesh's citizens should be educated and made conscious about ensuring acceptable levels of sanitation. In this regard, stress should be given on using BCC for informing the people on appropriate measures of sanitation.</li> <li>• The local government and the Public Health Engineering (PHE) department need to be linked up for enhancing the quality of public sanitation.</li> <li>• Waste disposal and hospital wastes in particular need to be effectively regulated. The hospital administration should, in collaboration with local authorities, introduce acceptable measure for managing the hygienic disposal of hospital wastes, keeping in view the guidelines of the environmental authorities.</li> <li>• The existing laws on sanitation should be enforced and channels of accountability for law enforcement need to be established.</li> <li>• A comprehensive and doable plan regarding waste disposal needs to be formulated.</li> </ul>	<ul style="list-style-type: none"> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are again planned for implementation in the next phase 3-year rolling HNPSPP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSPP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
9.	<b>Nutrition</b>	<ul style="list-style-type: none"> <li>• Relevant and updated information about nutrition needs to be disseminated amongst all households.</li> <li>• The National Nutrition Programme needs to be expanded to cover the entire country, modified on the basis of available experience.</li> <li>• In every upazila, a nutrition and health education unit should be set up to oversee the dissemination of information on nutrition and to monitor the nutritional status of every household.</li> </ul>	<ul style="list-style-type: none"> <li>• Planned for implementation in the next phase 3-year rolling HNPSPP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>

SL. NO.	AREAS	RECOMMENDATIONS	STATUS
10.	<b>Immunisation</b>	<ul style="list-style-type: none"> <li>• The present efforts in the field of immunisation should be evaluated and the existing programme needs to be continued through the commitment of additional resources to meet the needs of an expanded programme.</li> <li>• While the National Immunisation Day activities have been successful, the recent coverage of immunisation has not been so encouraging. Other immunisation programmes covering, for instance, Hepatitis B need to be introduced.</li> <li>• For reviewing the immunisation programmes, upazila and district level committees need to be activated.</li> <li>• Large-scale awareness raising programme on immunisation should be initiated by the MOHFW in collaboration with NGOs, such as BRAC, which have been involved in the immunisation programme for many years.</li> </ul>	<ul style="list-style-type: none"> <li>• Planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
11.	<b>Standardisation of Food and Drugs</b>	<ul style="list-style-type: none"> <li>• The administration should oversee food standards. The work of this facility should be backed by a definitive study on food standards which should serve as a benchmark for evaluating and maintaining standards. Till such a study is in hand, the existing food laws should be strengthened and may include penal provisions for providing substandard drugs and unhygienic food to the public.</li> <li>• To ensure proper standardisation of food and drugs, a network of efficient Food and Drugs Administration agencies should be developed.</li> <li>• To enact laws restricting spraying of chemicals on fruits and use of non bio-natural and non indigenous pesticides.</li> <li>• To enact laws prohibiting unhygienic and environmental conditions in fish cultivation.</li> </ul>	<ul style="list-style-type: none"> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• Planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP from 1<sup>st</sup> July 2003.</li> </ul>
12.	<b>Mapping of Diseases</b>	<ul style="list-style-type: none"> <li>• There is an urgent need to construct maps of all major diseases, on the basis of their incidence and prevalence, for each district.</li> </ul>	<ul style="list-style-type: none"> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> </ul>
13.	<b>Gender Disparities</b>	<ul style="list-style-type: none"> <li>• A special task force (consisting of members from relevant ministries) should be set up to identify the constraints as well as to propose remedial measures.</li> <li>• The task force can be empowered to monitor progress on establishing gender parity in access to health care and in health status.</li> <li>• Awareness measures and educational programmes need to be strengthened.</li> <li>• Special programmes to improve the nutritional status of girls need to be undertaken.</li> </ul>	<ul style="list-style-type: none"> <li>• No comprehensive plan documented in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</li> <li>• All of these were planned under HPSP. However, none of these were effectively implemented during HPSP period. These are</li> </ul>

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SL. NO.	AREAS	RECOMMENDATIONS	STATUS
		<ul style="list-style-type: none"> <li>• Topics on the health needs of both males and females and their impact on gender disparities should be included in school curricula.</li> <li>• Service providers at CC and higher levels should be given special training on gender equity.</li> <li>• The importance of ANC, delivery care and PNC should be communicated to all household heads at the grassroots level.</li> <li>• During ANC, delivery care and PNC, women should be offered counselling on the necessity of taking special food, iron and calcium tablets, and on the nutritional status of infants, irrespective of the sex of the child.</li> </ul>	<p>again planned for implementation in the next phase 3-year rolling HNPSP to be commenced from 1<sup>st</sup> July 2003.</p>

## HEALTH OUTCOME INDICATORS

OUTCOME INDICATORS	PRE HPSP	HPSP 2003 TARGET	CURRENT	COMMENTS
<b>1. Life Expectancy at Birth (Males and Females)</b> The average number of years of life that a newborn infant is expected to live under current mortality rates.	Males: 60.7 years Females: 60.5 years	Males: 62 Females: 62.5 years	Males: 68 Females: 69 years (HDS, BBS 2000)	The current status already exceeds targets. Life expectancy is difficult to calculate accurately due to absence of reliable data on age at death as Bangladesh does not yet have a comprehensive vital registration system.
<b>2. Infant Mortality Rate (IMR) (per 1000 live births)</b> Number of deaths in a year of children under 1 year of age, per 1000 live births in same year. Disaggregated by gender and socio-economic status.	57 per 1000 live births (BBS, 1998)	50 per 1000 live births	62 per 1000 live births (HDS, 2000); 71.5 for past 5 years; 66.7 for past 2 years (BMMS 2001).	Neonatal (first month of life) mortality currently accounts for about 2/3rds of infant deaths (45.4 out of 66.7). This proportion is increasing slowly, as post neonatal mortality is declining faster. Progress requires a reduction in neo-natal mortality. There is also considerable inequity with IMR being 68% higher among the poorest quintile than among the richest.
<b>3. Under 5 Mortality Rate (per 1000 live births), Male/Female</b> Number of deaths in a year of children under 5 years of age per 1000 live births. Disaggregated by gender and socio-economic status.	96 per 1000 live births (BBS)  115.7 per 1000 (DHS, 1996/97)	70 per 1000 live births	83 per 1000 (HDS 2000); 95.2 per 1000 (past 5 years); 84.6 per 1000 (past 2 years) (BMMS 2001)	Further progress requires a reduction in neo-natal mortality. Also the children in the poorest quintile households suffered 83% higher mortality than children in the richest households.
<b>4. Maternal Mortality Ratio (MMR) (per 1000 live births)</b> Number of maternal deaths in a year due to pregnancy-related causes during pregnancy or within 42 days of childbirth, per 1000 live births in same year. Disaggregated by socio-economic status.	4.1 per 1000 live births (HDS, BBS 1998)	2.8 per 1000 live births	3.2 per 1000 live births (Verbal autopsy, BMMS 2001)	The decline in MMR is partly due to the success in safe motherhood program.
<b>5. Malnutrition, moderate and severe underweight</b> Percentage of children 0-59 months of age: moderately malnourished (between -2.00 and -2.99 WAZ), and severely malnourished (below -3.00 WAZ) from NCHS/ WHO reference standards. Disaggregated by gender and socio-economic status.	Moderate: 35.7%; Severe: 20.6% DHS 1996/97	Moderate: 35%; Severe 8%	Moderate: 34.8%; Severe: 12.9% DHS, 1999/00	Malnutrition levels remain high, but HPSP did little outside of BINP to address this. Equity has deteriorated in both for moderate and severe malnutrition.
<b>6. Total Fertility Rate (TFR) per woman aged 15-49 years.</b> The average number of	3.3 (DHS 1996/97)	2.5	2.9 (HDS, 2000); 3.22 (BMMS 2001)	There is stagnation of fertility at about one child above replacement level (TFR=2.2) since early in the 1990's

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OUTCOME INDICATORS	PRE HPSP	HPSP 2003 TARGET	CURRENT	COMMENTS
children that would be born to a woman during her reproductive lifetime under current age-specific fertility rates. Disaggregated by socio-economic status.				
<b>7. Nutritional status of children and women</b> (Prevalence of women with Body Mass Index (BMI) less than 18.5).	70%	60%	45.4% (DHS 2000); 38.6% (HKI 2001)	Only micronutrient supplementation focused on control of nutritional anemia, and nutrition blindness (primarily financed by UNICEF) is being undertaken at the national level. Low birth-weight remains amongst the most serious in the world.
<b>8. STD prevalence among selected groups</b> Percentage of syphilis cases among targeted groups: sex workers, Men who have sex with men (MSM), truck drivers, and Ante Natal Care (ANC) seekers.	<u>Syphilis:</u> SW (41%); MSM (12%); ANC seekers (0.6%) Truck drivers (8%);	30% reduction in syphilis in all groups	<u>Syphilis:</u> SW (36.2%); MSM (10.9%); IDU (12.9%); STD clients (0.1%); Migrant workers – returnees (0.5%); Truck drivers (0.0%)	Syphilis incidence remains dangerously high amongst commercial sex workers (CSWs).
<b>3. Leprosy prevalence Rate per 10,000 population</b> Estimated leprosy prevalence per 10,000 population. Disaggregated by gender and socio-economic status.	0.96/10,000 (1998); 1.05/10,000 (1997)	<1 per 10,000 population by 2000	0.62 per 10,000 (June 2002)	Target exceeded.
<b>4. Incidence of polio</b> Total number of polio cases during the last year.	10 (1998) 29 (1999)	Reduced to 0 (3 years with no cases reported)	0 cases since August 2000 (1 case in 26/08/2000)	Target exceeded if maintained.

**Source:** Health and Population Sector Program, Status of Performance Indicators: 2002, A Report for the MOHFW and World Bank (Bangladesh Country Office) for Annual Programme Review 2002

## SERVICE CONSUMPTION INDICATORS

SERVICE CONSUMPTION INDICATORS	PRE HPSP	HPSP TARGET FOR JUNE, 2003	CURRENT STATUS	PROGRESS
<b>1. Use of ESP services (curative only) at Thana level and below, at public and NGO facilities, by sick population especially women, children and poor</b> (Percentage of total population that use or access one or more ESP services. Disaggregated by gender and socio-economic status)	13% at Public Facilities	80%	14%	No major improvement in access to ESP services.
<b>2. Percentage of fully immunised children. Percentage of children fully immunised against 6 diseases within first year of life.</b> Disaggregated by gender and socio-economic status.	46.9% at 12 months; 54.1% at 12-23 months (crude coverage: DHS 1996/97)	> 80%	56% at 12 months (valid doses only); 76% at 12-23 months (crude coverage) (EPI coverage survey 6/2002); 52.8% at 12 months; 62.1% at 12-23 months (DHS 1999-2000)	Three improvements have been reported since 2000: 1) a rise in the number of fully vaccinated children reflecting improved coverage/access; 2) a fall in drop-out rates; and 3) a fall in the number of abscesses (reported by mothers) as a result of vaccinations.
<b>3. Antenatal care</b> Percentage of pregnant women that sought ANC. Disaggregated by socio-economic status.	26.4% (1+ visits); 28.6% (DHS 1996/97)	65% of pregnant women made 1+ visits	47.5% (1+ visits) (BMMS 2001)	Doubling of ANC coverage since the early 1990s. However, it is still disturbing that of all women who had had a pregnancy, half had received no antenatal care whatever. The increase in ANC use was mainly among Nurse/midwife/FWV/ SACMO/MA providers, which could partly be due to the expansion of providers in this category. There was virtually no increase in doctors providing ANC.
<b>4. Met need for Emergency Obstetric Care (EOC)</b> (Proportion of women estimated with obstetric complications treated at facilities).	5.1%	30%	26.5% (1999) higher in 2002	Last year's report indicated an impressive rise in met need for EOC from 5.1% in 1994 to 26.5% in 1999, and there is evidence to suggest that there have been significant increases since 1999.
<b>5. Conduct of deliveries by skilled personnel (In home or in health facility)</b> Percentage of deliveries of target population conducted by skilled personnel (excluding TBAs) during the last one year. Disaggregated by socio-economic status.	8.0% (5.2% Doctor + 2.8% Nurse or Trained Midwife) (DHS 1996/97)	30%	11.6% (BMMS 2001); 12.7% (HDS 2000); 15% (SDS 2000)	Nine out of ten births still occur at home. The rest occur at a health facility. Only about one in eight deliveries (11.6%) in the past three years was performed by a medically trained person.
<b>6. Discontinuation rate of contraception</b> Percentage of eligible couples aged 15-49 years who discontinued use of (modern) contraceptive	46.9% (DHS 1996/97)	<25%	48.6% (DHS 1999/00)	No improvement.

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SERVICE CONSUMPTION INDICATORS	PRE HPSP	HPSP TARGET FOR JUNE, 2003	CURRENT STATUS	PROGRESS
methods.				
<b>7. CPR, with proportions for methods mix.</b> Percentage of currently married couples aged 15-49 years who are currently using contraception (specified by method)	49.2% (41.6% modern + 7.7% traditional) (DHS 1996-97)	60% using any method (of that 20% is traditional methods)	50.8% (44.5% modern + 6.3% traditional) (BMMS 2001)	While a CPR of 60% would be desirable, it is still below the level required to achieve replacement fertility by the GoB target of 2005.
<b>8. Vitamin A coverage</b> Proportion of children 9 to 59 months receiving Vitamin A capsules twice a year.	85% (IPHN/HKI 1997) 66.8% (DHS 1996/97)	>90%	84.1% (NCES 2002); 80% (DHS 1999/2000)	Expansion of Vitamin A coverage has been impressive over the past ten years, rising from 50 % in 1991 to over 90% in 2000 in rural Bangladesh.
<b>9. Detection of smear positive TB cases</b> Annual TB case detection rate of smear positive incidence cases. Disaggregated by gender and socio-economic status.	31.0% (1998)	70% of incidence cases by year 2005	31.4% (2001)	Little progress during HPSP.

**Source:** Health and Population Sector Program, Status of Performance Indicators: 2002, A Report for the MOHFW and World Bank (Bangladesh Country Office) for Annual Programme Review 2002